

Membership Application

To be completed by the prospective member

41 Washington Drive NE
Rome, GA 30161
706-413-2323
elevationhouserome@gmail.com
www.elevationhouse.org

Applicant's Name: _____

SSN: _____ DOB: _____

Address: _____

Email: _____ Phone: _____

Cellphone: _____

Race (check all that apply): American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Pacific Islander White Other: _____

Ethnicity: Hispanic Non-Hispanic
Primary Language: _____

Gender: Male Female
Marital Status: Single Married Divorced Widowed

Spouse's Name: _____
Living Situation: Independent With Relatives
 Boarding Home Homeless

Emergency Contact (1): Name: _____ Phone: _____

Relationship: _____

Emergency Contact (2): Name: _____ Phone: _____

Relationship: _____

Children? Please list the names and ages of your children:
Yes No

Currently Employed?
Yes No Where? _____ How Long? _____

Please provide 5 year Employment History- names of employers, dates worked and positions:

Current Source(s) of Income: _____ Monthly Income: \$ _____

Highest Level of Education Completed: _____

Reason for wanting to become a member (check all that apply): Basic Living Skills Therapeutic Socialization Skills Interpersonal Skills
 Prevent Psychiatric Hospitalization Managing Symptoms that interfere w/ Education/Employment
 Prevent Isolation Employment Support Independent Living Support
 Increase Self-Confidence/Motivation Improve Cognitive/Concentration Skills
 Mental Illness Management Reduce Negative Symptoms Develop Recovery Plan
 Prevocational Training Medication Support/Education/Compliance

Elevation House, Inc.

Member Rights and Responsibilities

PURPOSE:

To assure that all Members of Elevation House, Inc. (EHI) are informed of their rights and that such rights are respected throughout the Members involvement with EHI.

POLICY:

All individuals requesting services from (EHI) have a right to receive such service without regard to race, ethnicity, age, color, religion, creed, gender, national origin, sexual orientation, veteran status, financial condition, handicap or disability, HIV infection- whether asymptomatic or symptomatic, AIDS related complex or AIDS. No distinction will be formulated in determining eligibility for participation in services provided by EHI based on any of these identifiers, conditions or circumstances.

All individuals requesting services from EHI shall receive a *Statement of Member Rights* as part of the intake and initial orientation process, and, if appropriate, on an annual basis said statement shall conform to all applicable regulations issued by State, Federal and other funders. The following information is taken from the Georgia Department of Mental Health and is applicable to the Member of Elevation House.

Your Rights:

- You have a right to be informed of your rights.
- You have right to be informed regarding methods of resolving possible violations of your rights.
- You may seek advice and assistance from the Client Advocacy Program of the State of Georgia.
- You may contact an attorney of your choice.
- You have the right to be free from abuse, financial or other exploitation, retaliation, humiliation, and neglect;
- You have the right to access pertinent information in sufficient time to facilitate your decision making.
- You have the right to informed consent, refusal or expression of choice regarding service delivery, release of information, concurrent services, and composition of service delivery team.
- You have the right to access or referral to legal entities for appropriate representation, self-help support services, and advocacy services.
- You are entitled to a safe and humane environment.
- You have a right to as much freedom of movement as possible. This right may be limited only when it is necessary for the protection of you, others, and the community.
- You have the right to refuse treatment/therapy unless required by law.
- You have a right to participate in the formulation of your plan of care and to know the names of the staff members with whom you work with.
- You have a right to choose your rehabilitation provider and to discontinue your participation when you choose to.
- You have the right to refuse participation in any research project.
- You have a right to know the cost of your treatment and to know the source of any assistance available in meeting these expenses.
- You have a right to have all information concerning your treatment kept confidential

- except when State law permits disclosure.
- You may report any suspected abuse or neglect or exploitation of patients without fear or reprisal.
 - In exercising your rights, you may not infringe on the rights of others. You also have certain basic responsibilities and you have a right to know what is expected of you.

Your Responsibilities:

- Actively participate in your rehabilitation and help to develop your plan of care with an Elevation House staff member.
- Take part in planning and participating in your own psychosocial rehabilitation program and provide information concerning your mental health and medical history.
- Attend scheduled unit meetings at the Clubhouse and to select the unit of your choice to participate in.
- Contact Elevation House staff if you are going to be absent from the program. Cancel your transportation, if applicable, as soon as you know you will be unable to attend the program.
- Ask a question(s) when you do not understand what is happening to you.
- Let a member of the staff know when you have a problem or feel sick.
- Show respect for the property and rights of others.
- Obey the laws which apply to all citizens.
- Be familiar with and observe the rules and policies of Elevation House.
- Accept responsibility for your actions.
- Cooperate with the goal of achieving self-sufficiency in the management of your everyday living.

As a member of Elevation House you have a guaranteed right to a place to come, a guaranteed right to meaningful relationships, a guaranteed right to meaningful work and a guaranteed right to a place to return.

Grievance - Perceived Violation of Member Rights: The Executive Director shall serve as Member Rights Representatives for Elevation House and shall function in this capacity as specified in the Member Grievance Policy.

Elevation House, Inc. Notice of Privacy Policy

POLICY:

Elevation House, Inc. (EHI) will ensure the confidentiality of all information of persons served that is collected, stored, and disseminated by all EHI employees.

DEFINITION:

For all persons served, a release of information may be authorized by:

- A. The person served themselves as outlined in federal and state regulations.
 - 1. A guardian who has been granted specific authority by law for adults that have been adjudicated incompetent.
 - a. EHI reserves the right to request at any time a copy of any legal document(s) to support the above.

POLICY INTERPRETATION:

The Executive Director or designee shall be responsible for the interpretation of this policy.

PROCEDURE AUTHORITY:

The Executive Director or designee shall establish procedures to fully implement compliance with this policy.

PROCEDURE:

- A. All information in a record of a person served is considered confidential and shall be available only to authorized recipients.
- B. Limited information regarding the status of a person served may be released to the next of kin of the person served when it has been determined that such disclosure is in the best interest of the person served.
- C. Confidential information may be disclosed as part of certain legal proceeding as follows:

1. If a Court issues a written order compelling disclosure; provided, however, that if a Court issues a subpoena or court order for records relating to alcohol and/or drug abuse treatment, then the appropriate staff person will go before the Court and advise the court that a team meeting should be held to determine where there is good cause to require disclosure of the record.
 2. The staff person who answers the subpoena will take a copy of the federal regulations for reference for the presiding judge.
 3. If a Court issues a witness subpoena requiring the recipient to appear and testify at a court proceeding, the recipient must appear at the proceeding at the specified date, time and place. If the proceeding is a trial or other hearing in court and the person served attends the proceeding the person served will have the opportunity to raise claim of "privilege" or "confidentiality". The court will then determine if the recipient must testify. If the person served does not attend the proceeding and has not authorized the release of the information the recipient shall alert the court that the testimony contains privileged or confidential information and the person served has not authorized the release of information. It will be the judge who has the responsibility to decide if the recipient must testify.
 4. For purposes of filing a petition for involuntary commitment, or a petition for adjudication of incompetence and the appointment of a guardian.
 5. If the person served is voluntarily admitted or involuntarily committed and facing a district court hearing, such information as may pertain to the necessity for admission or continued stay in the facility.
 6. If the information is relevant to litigation involving EHI and relating to the operation or services of EHI.
 7. So called " re-disclosures" of information in records of the person served derived from other sources under conditions of confidentiality will be treated exactly like other disclosures.
 8. Additional legal counsel may be sought when special or unusual information about an individual person served is requested by the courts, public officials, investigative units, or law enforcement bodies.
- D. Confidential information indicating that physical or sexual abuse of children, disabled persons, or others identified in mandatory reporting statutes is occurring or has occurred must be disclosed to the appropriate authorities as authorized by relevant statutes.
- E. Confidential information may be disclosed with the signed authorization of the person

served as part of the care and treatment of an individual as follows:

1. Information may be shared among employees, students, volunteers and consultants of EHI who have a need to know for reason of shared treatment, supervision, and quality assurance, or billing.
 2. Information may be shared with other state facilities upon written determination by a responsible professional that such disclosure is necessary to coordinate appropriate and effective care, treatment, or habilitation of the person served, and/or that failure to share information would be detrimental to the care and treatment or habilitation of the person served.
 3. Information may be shared with a physician or other healthcare provider who is providing emergency medical services to a consumer.
- F. Confidential information may be disclosed without the authorization of the person served with regard to payment by a third party for services provided to the person served. Such information shall generally be limited to what is necessary to document the type and amount of service provided, that the person served is eligible for services, and that services were provided in accordance with the standards established by the payer. Information may be shared with authorized personnel and/or designated agents of the South Carolina Department of Health and Human Services and the South Carolina Department of Mental Health with regard to persons served in part with public funds. Information may be shared with authorized agents of Medicaid, Medicare, commercial insurance carriers, employers who self-insure for health benefits and other organizations/agencies who agree to pay for services provided by EHI.
- G. Confidential information may be disclosed with the authorization of the person served when a responsible professional determines that in their opinion there is imminent danger to the health and /or safety of the person served, of another individual, or there is likelihood of the commission of a felony or violent misdemeanor. Information may be disclosed to a potential victim of violence or danger to relatives or others who may be in a position to protect or deter the person served, to the police or courts, or other guardians of the public safety, and to others as appropriate. The responsible professional shall review the federal regulations (42 C.F.R., Part II) as they apply to duty to warn. An administrative review is necessary on all records when information is disclosed as a duty to warn.

- H. Upon admission and updated yearly thereafter, all members of the Clubhouse are requested to sign a release of information giving EHI permission to publish their names, photographs and articles they may write or be included in the " EHI News." This also includes the use of photographs on the GHJ website, brochures, or other audio/visual presentations. If said release is not signed by a person served or representative, no such information or likeness of said person served will be used in any of the aforementioned media.
- I. EHI and the local mental health centers have a written contract to freely share confidential information regarding persons served. EHI staff are prohibited from releasing any confidential information regarding a person served that was obtained from another source without obtaining the written informed consent of the person served.
- J. All EHI staff are required to sign a statement that they have read and understand the policies and procedures.
- K. All consents to release information must be with informed consent and voluntarily given. Persons served or their designated responsible person shall be told that the provision of service is not contingent upon such consent and the need for such release.

EHI may disclose the admission or discharge of a person served whenever the designated responsible professional makes the determination that disclosure is in the best interest of the person. Request for admission or discharge must be in written form.

Elevation House, Inc.
Consent & Release Form

Consent to Treatment: **Accept** **Decline**

Consent and authority is hereby given to Elevation House, Inc. and its staff to perform Rehabilitative Psychosocial Services and/or related mental health services and treatments deemed necessary by appropriate members of the professional staff as authorized in consultation with me. This statement has been fully explained to me and I understand it.

Notice of Privacy Practices: **Accept** **Decline**

I have been provided a copy of the Elevation House, Inc. Notice of Privacy Practices and an opportunity to review it and ask questions.

Member Handbook/Member Rights & Responsibilities: **Accept** **Decline**

I have been provided a copy of the Member Handbook and Member Rights and Responsibilities and was provided an opportunity to review and ask

Photograph/ Video Release: **Accept** **Decline**

I hereby authorize Elevation staff and members to videotape me and take photographs of me to use for informing other members, family members and the general public about the services and opportunities available through Elevation to include: social media, bulletin boards, displays, website, etc.

I further authorize that my full name and photograph be used in Elevation House media, reports and publications.

Family/ PCP Release: **Accept** **Decline**

I hereby give Elevation staff permission to communicate with my family or primary care provider regarding the services I receive at Elevation House as it relates to my progress and plan of care.

By signing below, I indicate that I hereby understand and agree to all of the above marked statements and acknowledge that this consent is truly voluntary and valid. I further acknowledge that I may revoke this consent at any time except where actions based on prior consent have already taken place.

Member Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Title/ Position: _____

Elevation House, Inc.

Financial Agreement & Third Party Payers Release Consent

Thank you for choosing Elevation House, Inc. (EHI) as a provider. We are committed to providing you with quality care. The following is a statement of our financial policy which we require that you read and accept prior to receiving Rehabilitative Psychosocial Services (RPS) or other mental health services ("Services").

In consideration for the Services provided, I/we accept financial responsibility to pay EHI. Payment is expected at the time of Service unless other arrangements for payment have been made directly with EHI or through my insurance company, Medicaid, or Medicare ("Third Party Payers"). I have identified a Third Party Payer who is responsible for payment for all or a portion of the Services provided to me by EHI.

Third Party Payers require that EHI provide them with healthcare information and/or records in order for the Third Party Payer(s) to verify that I am eligible to receive Services or to reimburse or pay for Services provided by EHI. I consent to the release of my healthcare information or records to my Third Party Payer. The healthcare information or records released will include that which is necessary to establish my eligibility for Services and to establish a claim for reimbursement for Services provided to me consistent with the policy, procedures and requirements of my Third Party Payer(s).

I have been provided a copy of EHI's Notice of Privacy Practices that explains the uses and disclosures that EHI will make with respect to my healthcare information. I understand that EHI cannot use or disclose this information other than as provided in the Notice. I understand that I have the right to request restrictions on the disclosure of information from my record for payment purposes. However, if the result of this restriction is that my Third Party Payer will not pay EHI for the Services provided to me, EHI is not required to agree to this restriction unless I make other payment arrangements. If I have an outstanding balance, it is my responsibility to contact the Third Party Payer(s). Payment of the outstanding balance is my/our responsibility. Signing below confirms my responsibility to pay any outstanding balances.

Additionally, your signature on this form will be utilized as your "Signature on File". This "Signature on File" authorizes us to bill your Third Party Payer(s) and authorizes that payment for Services will be directed to EHI as your service provider.

I have carefully read and agree to the terms of this agreement and further consent to the use and disclosure of my healthcare information for payment purposes.

Member Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Title/ Position: _____

Elevation House, Inc.
Member Billing Information Sheet

Member Full Name: _____	
Social Security Number: _____	
Sources of Income:	Amount:
*Monthly Income:	
Financial Assets:	Amount:
Monthly Deductions:	
Medical Deductions:	Amount:
Medical Expenses:	
Medication Expenses:	
*Allowable Deductions:	
Adjusted Income *(Monthly Income-Allowable Deductions) :	
Medicaid: Yes <input type="checkbox"/> No <input type="checkbox"/>	SSI: Yes <input type="checkbox"/> No <input type="checkbox"/>
	SSDI: Yes <input type="checkbox"/> No <input type="checkbox"/>
Private Insurance: Yes <input type="checkbox"/> No <input type="checkbox"/>	Insurance Carrier: _____
Service Fee: _____	

Member Signature: _____ Date: _____